



The Importance of Integrated Services

A system of services is a family-centered network of community-based services that is designed to promote the health and well being of CYSHCN and their families. Ideally, community-based service systems are organized so families can use them easily. Care coordination, access to a medical home, family-centered and culturally competent services are considered key elements of coordinated services for families of CYSHCN. However, many families of CYSHCN face frustration accessing services. Eligibility requirements, policies, procedures, and multiple locations of services can leave families feeling overwhelmed. There are often gaps in services due to agencies that provide limited services or duplication in services from multiple coordinators and service plans. Families may also need to travel great distances to obtain specialized services.

The examples in the following sections, from medical home, care coordination, family-centered care, to cultural competency, as well as the common application forms found in the health information technology section, all address some piece of a coordinated system of care—although no state or community addresses all issues equally well. The following models of care often use strategies recommended by Champions for Inclusive Communities for developing coordinated services: including the use and development of interagency councils, partnerships with coalitions, supporting the development of family leadership and family-directed programs, and promoting linkages at the local and state level. For local level examples, please refer to the Star Communities on the Champions website: www.Championsinc.org.

The Importance of Integrated Services

Medical Home

All states, including California, have some type of initiative in place to promote the Core Outcome established by MCHB of ensuring that “children and youth with special health care needs receive coordinated ongoing comprehensive care within a medical home.” Leaders in medical home efforts believe that two pieces are essential to the success and sustainability of the medical home: policy and payment. Clear policies should support the location of medical homes in the primary care setting and help facilitate practice transformation. Practices need to invest in the involvement of families in decision-making, trusting the care coordinator, and learning how to work as a team and to link with the larger community. Financial incentives are necessary to help practices undergo such a transformation, and enhanced reimbursements, mini-grants, and other financial supports are essential. For this report, AMCHP is using the American Academy of Pediatrics’ (AAP) definition of medical home: “A medical home is defined as primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective.

States have had varying degrees of success, with some leaders concerned that a recent push for medical homes in the adult health care community (and accompanying National Committee for Quality Assurance (NCQA) standards) may eclipse the momentum for medical homes in the child community. In addition, while evaluations for the success of a pediatric medical home may be more complex than those for an adult medical home, they are still necessary.

Four states—Illinois, Pennsylvania, Colorado, and North Carolina—have been consistently cited as strong and unique examples of how the medical home process can work. While each model features different strengths, including the extent to which the needs of CYSHCN are addressed, all include a strong state level Medical Home advisory group, involving the AAP as well as other provider groups, and strong buy-in of state agencies.

ILLINOIS: USING FACILITATORS TO PROMOTE MEDICAL HOME QUALITY IMPROVEMENT IN PRIMARY CARE PRACTICES

Public/Private Emerging Practice

The Illinois Medical Home Project (IMHP) is administered by the Illinois Chapter of the American Academy of Pediatrics (ICAAP) in collaboration with the Illinois Title V CYSHCN program (known as the Division of Specialized Care for Children). The goal of the Illinois project is to use medically trained facilitators to provide a structure for implementing quality improvement in pediatric and family physician primary care practices to promote community-based and family-centered medical homes. The Illinois project is highly regarded because of its strong evaluation piece and its success in gaining private grant funding to sustain the program.

System of Care: The Division of Specialized Care for Children (DSCC) and the Illinois AAP chapter help practices by providing access to quality improvement (QI) processes involving partnerships with parents, linkages to community resources, and

modest mini-grants. Nine practices are currently participating. Facilitators are generally professionals such as nurses, social workers and speech pathologists who are care coordinators for families served by DSCC and have received extensive training in the concepts of the medical home model and in facilitation. Once facilitators are assigned to a practice, their first assignment is to help the practice do a medical home assessment using the Medical Home Index and a modified form on the Medical Home Family Index designed by Dr. Carl Cooley at the Center for Medical Home Improvement (http://www.medicalhomeimprovement.org/pdf/PediatricMedicalHomeFamilyIndexandSurvey_2005.pdf). Some practices hired a care coordinator, while others delegated care coordination responsibilities to practice staff.

Financing: Practices also receive modest (originally \$5000 annually) mini-grants to use for such items as providing stipends for family members to attend meetings, purchasing necessary computer equipment to support the project, purchasing USB drives for families to store care plans, or for compensating parents to design a resource guide for the practice. These mini-grants are considered a modest but essential piece of the program. They have been particularly helpful in recruiting medical home practices to establish a Quality Improvement team. The mini-grant amounts have been reduced in the current phase of the program because practices were not using the full \$5000. In addition, participating practices could choose to participate in the larger state Medicaid Primary Care Case Management Program (which primarily focuses on the assignment of a primary care provider as a medical home) and receive monthly case management fees based on number of patients on their roster (per member/per month). PCPs may also receive performance bonuses for achieving certain levels of compliance with specific practice standards.

The IMHP was originally supported through a \$1,000,000 nearly five-year grant to ICAAP from the federal Maternal and Child Health Bureau and is now sustained by a grant from the Michael Reese Health

Trust (an Illinois Foundation). The second phase of the original grant was designed to determine the effect of the medical home training sessions, resources, tools and curriculum provided to all practices, as well as what effect facilitators have on the process and outcomes when implementing a medical home plan.

Evaluation: Throughout Phase II of the grant, nine practices participated in the Illinois Medical Home Project. The grant was evaluated by the University of Illinois at Chicago School of Public Health's Center for the Advancement of Distance Education (CADE). The evaluation used tools such as the Center for Medical Home Improvements' (CHMI) Medical Home Index and found improvements in delivery of care, access to community services, satisfaction with care received, and changes in provider and family competencies. For more information, visit the project website at www.illinoisap.org/medicalhome.htm.

Will it Work in California: This project may be of interest and replicable in California because it is sustained by private grant funding. A key issue would be the costs of training the facilitators, which was an in-kind expense for ICAAP and DSCC.

Sources in addition to expert interviews: 1) Kaye, N., Takach, M. Building Medical Homes in State Medicaid and CHIIP Programs. National Academy for State Health Policy. Copyright 2009 (www.nashp.org) 2) State of Illinois Title V Block Grant Application Narrative, FY 2009. Retrieved August 7, 2009. <https://perfddata.hrsa.gov/mchb/tvisreports/>.

PENNSYLVANIA: A MEDICAL HOME IN EVERY COUNTY

Public/Private Emerging Practice

Pennsylvania's Medical Home Initiative, Educating Practices in Community Integrated Care (EPIC-IC) is a medical home development project, and is the largest CYSHCN Medical Home Program nationally, based on both the number of participating medical home practices and the number of children identified in the project's patient registry. The project has been cited for the breadth of involvement across the state,

the strength of its data collection system, including the development of patient registries, and its payment system. The project is a collaborative effort of the Pennsylvania Department of Health—Division of Special Health Care Programs (Title V), family community organizations, and the PA Chapter of the AAP.

System of Care: The EPIC-IC medical home project is based on the Educating Physicians In their Communities (EPIC) model. EPIC-IC is a statewide provider of education/quality improvement programs, using office-based change as the key to improving the care provided to CYSHCN. The mission of EPIC-IC is to enhance the quality of life for CYSHCN through recognition and support of families as the central caregivers for their child, effective community-based coordination, communication, and improved primary health care. The EPIC-IC project facilitates the provision of medical homes to CYSHCN throughout the Commonwealth of Pennsylvania.

Since its inception in 2002, the EPIC-IC Pennsylvania Medical Home Initiative has provided Medical Home training to over 100 practice sites, 53 of which continue ongoing quality improvement activity. Currently, there are 31 practice sites that are in recruitment. Thus, the PA Medical Home Initiative currently works with 84 practice sites. These practices represent 37 counties in all six regions of Pennsylvania, including urban, suburban, and rural areas and multiple ethnic/racial groups. Among the practice sites are Federally Qualified Health Centers, Rural Health Centers, and three major children's hospital systems. The size of the participating practices varies from 1,500-30,000 patients. EPIC-IC has a goal of having a Medical Home practice in each of the 67 counties in the state to foster dissemination and sustainability of medical homes for CYSHCN.

In order to participate in the program, practices work with EPIC-IC to meet many care coordination criteria. The criteria include the following: 1) Identification of practice team members; 2) Recruitment of Parent Partners to work with the practice team; 3) Development of a process for creating a comprehensive and continuously updated patient registry of CYSHCN; 4) Submission of a brief monthly report; 5)

Collaboration with local, community-based organizations; 6) Participation in EPIC-IC monthly conference calls; and 7) Attendance at EPIC IC conferences.

Financing: EPIC-IC is funded by the Pennsylvania (PA) Department of Health (Title V) and the federal Maternal Child Health Bureau. EPIC-IC provides mini-grants for care coordination to practices based on certain criteria. In addition, some (not all) payors provide reimbursement for such items as care plan development and oversight, telephone calls and patient conferences.

Evaluation: Similar to other quality improvement projects, EPIC-IC uses many tools to measure and monitor strengths, weaknesses, outcomes, and successes of the project. A number of measurement instruments have been developed for the project, with validated tools used to monitor the progress of the Medical Home Initiative with the practices that have received training.

Will it Work in California: Pennsylvania's Medical Home system encompasses the type of systematic overhaul of pediatric care for which experts advocate. Such an initiative in California would require the strong partnership of AAP Chapters, buy-in from health plans, and a solid investment in the infrastructure (e.g., CYSHCN patient registries) needed to build such a system.

Sources in addition to expert interviews: 1) Pennsylvania Medical Home website: www.pamedicalhome.org, 2) State of Pennsylvania Title V Block Grant Application Narrative, FY 2009. Retrieved August 7, 2009. <https://perfddata.hrsa.gov/mchb/tvisreports/>.

NORTH CAROLINA: ENHANCED PRIMARY CARE CASE MANAGEMENT SYSTEM

Public/Private

Promising Practice

North Carolina has been recognized nationally as a leader for its comprehensive Medical Home project. Although it is not specifically targeted to CYSHCN, experts repeatedly mentioned the program as worthy of review because it has been in place for so long and

so thoroughly evaluated. In addition, in recent years a number of efforts have been made to address the needs of CYSHCN. Also, North Carolina, similar to California, has a strong county health system.

System of Care: North Carolina's coordinated care/medical home effort began in 1998 as a one-county pilot called Community Care, based on an earlier Primary Care Case Management (PCCM) program for Medicaid that began in 1991. The program was taken statewide in 2005 as Community Care of North Carolina (CCNC) through the creation of 14 local/regional networks across the state. Each network includes primary care providers, safety net and specialty care providers in collaboration with the local health departments, departments of social services and hospital(s). (Source: Governing, Medical Home). Primary care providers direct the care that CCNC enrollees receive.

Financing: North Carolina pays two fees per member per month for each enrolled individual—one to the primary care provider and one to the network to which the provider belongs. The networks use this payment to pay for medical home supports that a single practice might not be able to afford. For example, networks have hired: 1) a part-time or full-time medical director to oversee quality, meet with practices and serve on the State Clinical Directors Committee; 2) a pharmacist for medication management; 3) a clinical coordinator/director to oversee network operations; and 4) care managers to assist practices with such services as case management and coordination across delivery settings, as well as support in implementing practice improvements recommended by CCNC.

Evaluation: An outside analysis by Mercer Consulting showed that North Carolina Community Care operations in State Fiscal Year 2004 saved \$244 million in overall healthcare costs for the state while improving overall health outcomes for select illnesses. Subsequent analyses in 2005 and 2006 found similar results. In 2007, the North Carolina state legislature mandated CCNC coverage for all of the state's aged, blind and disabled recipients in addition to all recipients of the State Children's Health Insurance Program.

Special Initiatives for CYSHCN: While North Carolina's general program is not specifically directed to CYSHCN, over the last four years CCNC has used grant funding from two North Carolina foundations to partner with pediatric subspecialists in six major North Carolina medical centers to improve coordination of care of CYSHCN both within each medical center and between the medical center and each patient's medical home. CCNC continues to evaluate the cost and quality outcomes of its programs and is planning new initiatives for adults and children in integrated behavioral health delivery.

In addition, the North Carolina Medical Home Initiative for CYSHCN has collaborated with a variety of networks in the CCNC to meet the medical home needs of these children. For example, in one regional network, Partnership for Health Management, four practices within the Partnership for Health Management have incorporated the medical home index and family survey tools, pre-visit contacts, CYSHCN registries, and complexity ratings in their practices. In a separate network, Chapel Hill Pediatrics (CHP) received a commendation from MCHB in the "Promising Approaches" document of the Federal Expert Workgroup on Pediatric Subspecialty Capacity for its inclusion of the pre-visit contact. Data from Blue Cross/Blue Shield of NC indicated emergency room utilization for CYSHCN was significantly lower in this practice than in other area practices.

The Managed Care Solutions Committee (originally sponsored by the NC Pediatrics Society, now known as the Pediatric Council) has sponsored statewide trainings for health care providers on billing for medical home related services for CYSHCN. Cost-savings data, attributed to the utilization of the medical home approach, have been collected by the 14 provider networks within Community Care of NC, the first medical home demonstration project, and from ongoing data collection as part of the second medical home demonstration project, which targets numerous Community Care of NC practices. Data have demonstrated favorable results thus far regarding the reduction of Emergency Department (ED) usage and hospitalizations among CYSHCN. The NCPS

has created a Quality Improvement Committee over the last year, which will explore ways to promote the use of the NCQA Patient Centered Medical Home process to advance the medical home concept among pediatricians and others who care for children and youth in North Carolina.

Will it Work in California: While the CCNC program is not specifically directed to CYSHCN, it is building the capacity to address the needs of CYSHCN, and is part of a larger system with well-established evaluation methods and cost-savings data. The evidence of cost-savings, in particular, could be very compelling in tight economic times. The CCNC could be piloted in counties or across the state in California, although it is important to note that the NC system is not a managed care network.

Sources in addition to expert interviews: 1) Kaye, N., Takach, M. Building Medical Homes in State Medicaid and CHIIP Programs. National Academy for State Health Policy. Copyright 2009 (www.nashp.org) 2) Community Care of North Carolina (www.communitycareNC.com) 3) Buntin, John. "Health Care Comes Home," March 1, 2009 *Governing Magazine*. Retrieved August 12, 2009. (www.Governing.com/node/633) 4) State of North Carolina Title V Block Grant Application Narrative, FY 2009. Retrieved August 12, 2009, <https://perfddata.hrsa.gov/mchb/tvisreports/>.

COLORADO: MEDICAL HOME FOR ALL CHILDREN, POLICY CHANGES AND BROAD-BASED SUPPORT

Public/Private Emerging Practice

Colorado is a western state with a strong county health department system. While its population is a fraction of California's, Colorado's approach to building a medical home system by focusing on medical home teams for all children, supporting collaborative partners, the policy changes which enable change, and the diversity of funding merit review.

System of Care: The Colorado approach to the Medical Home concept states that "Colorado is going beyond traditional definitions of a medical home by

identifying it as a team approach to health care. Colorado is also building a Medical Home System, which is the infrastructure to support a Medical Home Team for all families." The Colorado Medical Home Initiative is housed in the Title V agency and is directed by a parent leader who also serves as the family leadership director for the state.

The Colorado Medical Home Initiative began in 2001 in response to the Title V/Maternal and Child Health (MCH) national outcome measure, *all children will receive comprehensive coordinated care within a Medical Home*. The Colorado Medical Home Initiative looks to serve as a neutral facilitator in identifying barriers while promoting solutions in developing a quality-based system of health care for children. The Colorado Medical Home Initiative is currently working to promote the medical home team approach and implement the medical home system in four local communities in Colorado. These communities are supported with technical assistance and resources as they develop community Medical Home Improvement Teams committed to implementing the medical home team approach through systems development.

The Medical Home Initiative in Colorado is supported by state legislation. Senate Bill 07-130, signed by Governor Ritter in 2007, designates the Department of Health Care Policy and Financing (HCPF) to take the lead in assuring an increase in the number of children who have access to a Medical Home team, specifically those children eligible for Medicaid and SCHP in Colorado. Colorado's Medicaid agency, the Department of Health Care Policy and Financing (HCPF) is responsible for collaborating with the Colorado Medical Home Initiative to implement the requirements of the bill, creating an effective braiding of direct care services and systems-building efforts.

Financing: In terms of financing, Colorado's Department of Health Care Policy and Financing is piloting a program to pay an enhanced fee to primary care providers who meet particular medical home standards during all Early Periodic Screening, Diagnosis and Treatment (EPSDT) visits. The enhancement is calculated to be about the equivalent of \$3 per member per month for a year (\$36).

Collaboration: Colorado's Medical Home Initiative concept enjoys the support and endorsement of many state organizations, including the state chapters of the AAP and AAFP, Kaiser Permanente, The Children's Hospital Denver, and several family organizations including Family Voices. Colorado's Medical Home Standards for children, a deliverable of the medical home legislation, were developed in 2008 by the Colorado Medical Home Initiative's evaluation task force made up of family leaders, mental, oral and physical health providers, NCQA, local chapters of the AAP and AAFP, researchers and state agency staff.

Family Registry Data: The Colorado Medical Home Initiative is also developing a centralized database of all emerging family/youth leaders to capture specific areas of expertise and core competencies. Developed with a strong evaluation component, the database will be able to track the progression of family leaders. In addition, the information will have a query function that will serve to match family leaders with specific opportunities.

Evaluation: The Colorado Medical Home Initiative works hard to integrate all medical home efforts within the state. In particular, impressive outcomes have been demonstrated through the partnership of the Colorado Medical Home Initiative with the Colorado Children's Healthcare Access Program (CCHAP).

The Colorado Children's Healthcare Access Program is a non-profit organization devoted to ensuring that children enrolled in Medicaid and the SCHIP program have access to comprehensive healthcare through private primary care providers in order to build a medical home team approach. In addition, CCHAP supports providers through a process of self-assessment using the Colorado Medical Home Standards in conjunction with the Medical Home Index. Through this thorough self-assessment process, providers are able to identify areas of need/strengths related to their process to provide a medical home approach. CCHAP then works with the Colorado Department of Health Care Policy and Financing to determine if the provider is eligible to receive an increase in their reimbursement rate.

Will it Work in California: California may want to look at Colorado's strategy of ensuring for *all* children as a mechanism for broad-based support of the concept. In addition, Colorado's reimbursement process and family registry may also be of interest as discrete approaches. At the same time, it is important to note that Colorado's size, population and diversity (as well as economic status) is smaller and more homogeneous than California.

Sources in addition to expert interviews: 1) Kaye, N., Takach, M. Building Medical Homes in State Medicaid and CHIIP Programs. National Academy for State Health Policy. Copyright 2009 (www.nashp.org) 2) State of Colorado Title V Block Grant Application Narrative, FY 2009. Retrieved August 12, 2009. <https://perfdata.hrsa.gov/mchb/tvisreports/> 3) Colorado Children's Healthcare Access Program (www.cchap.org).